METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

Revised 09-01-01

A. COST ANALYSES

The Oklahoma Health Care Authority (OHCA) is principally responsible for implementing the Medicaid program in Oklahoma. OHCA staff will prepare necessary analyses to support the rate determination process, as described below.

1. UNIFORM COST REPORTS

Each Medicaid-participating ICF/MR facility must submit, on uniform cost reports designed by the Authority, cost and related statistical information necessary for rate determination.

a. **Reporting Period.** Each ICF/MR facility must prepare the cost report to reflect the allowable costs of services provided during the Immediately preceding fiscal year ending June 30. Where the ownership or operation is commenced, a fractional year report is required, covering each period of time the ICF/MR was in operation during the year.

b. **Report Deadline.** The report must be filed by September 1 of each year. Extensions of not more than 30 days may be granted on a showing of just cause.

c. **Accounting Principles.** The report must be prepared on the basis of generally accepted accounting principles and the accrual basis of accounting, except as otherwise specified in the cost report instructions.

d. **Signature.** The cost report shall be signed by an owner, partner or corporate officer of the ICF/MR, by an officer of the company that manages the NF, and by the person who prepared the report.

e. **Audits of Cost Reports.** The Authority will conduct a desk review to verify the completeness and mathematical accuracy of all totals and extensions in each cost report. Census information may be independently verified through other OHCA sources. In addition, a sample number of cost reports will be audited independently by an auditor retained by OHCA. Any ICF/MR that is subject to an audit is required to make its records available to OHCA and to any auditor engaged by OHCA.

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2. ALLOWABLE AND UNALLOWABLE COSTS

Only "allowable costs" may be included in the cost reports. (Costs should be net of any offsets or credits.) Allowable costs include all items of Medicaid-covered expense that ICF'S/MR incur in the provision of routine (i.e., non-ancillary) services. "Routine services include, but are not limited to, regular room, dietary and nursing services, minor medical and surgical supplies, over-the-counter medications, transportation, and the use and maintenance of equipment and facilities essential to the provision of routine care. Allowable costs must be considered reasonable, necessary and proper, and shall include only those costs that are considered allowable for Medicare purposes and that are consistent with federal Medicaid requirements. (The guidelines for allowable costs in the Medicare program are set forth in the Medicare Provider Reimbursement Manual ("PRM"), HCFA-Pub. 15.) Ancillary items reimbursed outside the NF rate should not be included in the ICF/MR cost report and are not allowable costs. Quality of Care assessment fees are allowable costs for reporting purposes.

3. COMPUTATION OF THE STATEWIDE FACILITY BASE RATE

Cost reports used to calculate the rate were those filed for the year ended June 30, 1999. ("base year"). A state plan will be submitted when costs are rebased. A description of the calculation of the base per diem rates for the periods beginning September 01, 2000, October 01, 2000, and December 01, 2000 are as follows:

A. Primary Operating Costs

1. Determine the weighted mean primary operating per diem by summing all reported primary operating expenses of all standard ICF/MR facilities and dividing by total period patient days. Primary operating costs consists of all non-capital costs excluding administrative services, which are described on page 4.

2. Determine the audit adjustment per diem to be extrapolated to all reporting facilities based on the desk reviews and independent sample audit findings. The audit adjustment is based on an average of the difference between the reported costs and audited

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costs. If no audit file is available, an average audit adjustment will be determined from the average audit adjustments for the last five available periods.

For the rate period beginning 09-01-01 an audit adjustment which reflects the latest available audit data will be made. This adjustment will be made to the base primary operating cost before trending forward to the midpoint of the state fiscal year of the rate period by the factors defined in 3.A.4, below. The new adjustment will be the difference between the factor determined in the previous rate as defined above and the average of the three most current available years audit data on file.

3. Determine the adjusted primary operating per diem by subtracting the audit adjustment per diem (step 2) from the weighted mean primary operating costs per diem determined in step 1.

4. Trend forward the adjusted primary operating per diem from the midpoint of the base year to the midpoint of the rate period state fiscal year using the inflation update factors. The Authority will use the update factors published in the Data Resources, Inc., ("DRI") nursing home without capital marketbasket index for the fourth calendar quarter of the previous fiscal year.

   For example, for the rates effective July 1, 1997, the Authority used the update factors for the fourth quarter of calendar year 1996.

B. Administrative Services

An imputed administrative services allowance will be used in lieu of actual owner/administrator salary and non-salary compensation. The imputed administrative services allowance is the state-established limit or value for the purposes of calculating the reimbursement rate.

The base allowance will be the same as that determined for the regular Nursing facilities in 3.B on pages 3 and 4. The allowance will be trended forward in the same manner as in 3.A.4 on page 3.

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C. Capital

An imputed allowance will be used in lieu of actual depreciation, interest, and lease related to facilities and equipment. The imputed allowance is determined by dividing the total reported costs (from the base year cost reports) for the regular nursing facilities, plus that for the regular nursing facilities serving aids patients, plus that for the private standard intermediate care facilities for the mentally retarded plus that for the private specialized (16 bed or less) M/R facilities by the total "adjusted days" for those facilities. The "adjusted" days are determined by multiplying the allowable days from the base year cost report by a factor of .93 (i.e. adjust to a 93% occupancy level). To account for inflation this imputed capital allowance will be trended forward to the rate period state fiscal year by the Marshall-Swift replacement cost multipliers for facilities with Class C construction (District Comparative Cost Multipliers, Central Region) published in the January index of the year preceding the rate change period.

D. Adjustment For Change In Law Or Regulation

The Authority also considers possible effects on rate year costs compared to base year costs that might not be fully accounted for by the DRI index described above. Inasmuch as the index is an estimate of actual and forecasted national rates of change in the price of nursing home goods and services, DRI is not specific to any state. Thus during a given period, it might not sufficiently account for the economic effects of changes in federal laws or regulations which have a disparate impact on Oklahoma, or of changes in state laws, rules or circumstances that only affect Oklahoma.

The following circumstances may cause an adjustment to rate year costs: additional costs incurred to meet new requirements imposed by government regulatory agencies, taxation, authorities, or applicable law (e.g., minimum staffing requirements, social security taxation of 501(c) (3) corporations, minimum wage change, etc.) and implementation of federal or state court orders and settlement agreements.

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OHCA will evaluate available financial or statistical information, including data submitted on cost reports and special surveys to

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calculate any base rate adjustment. These adjustments will become permanent until such time a state plan amendment is submitted to rebase the rates.

Per HB 2019, the Oklahoma 2001 Health Care initiative, the following adjustments will be made.

1. For the rate period beginning September 1, 2000 the OHCA has calculated an Oklahoma Specific additional cost of expected increase in Liability insurance rates. The rate will be adjusted by an additional $.51 for the expected cost. The amount of additional cost was determined from a sample of nursing facility invoices from the 1999 and 2000 fiscal years and from data from the base year cost reports. The total sample costs for 1999 were compared to the total sample costs for 2000 to get an overall percent of increase. Total available days from the base year cost report was divided by 365 to estimate the number of beds which in turn was multiplied by an estimated annual cost of $100 per bed (per industry survey) to get an annual estimate for the rate year period. The resulting cost was divided by the total patient days from the base year cost reports and multiplied by the percent increase from above to determine the added cost per day.

   This add-on will be trended forward by the same method as in 3.A.4 on page 3.

2. For the rate period beginning September 1, 2000 the OHCA has calculated the additional cost of new direct care staffing requirements. These new requirements are to maintain staff-to-patient ratios of 1:8, 1:12 and 1:17 for the three 8 hours shifts for day, evening and night, usually beginning at 8:00 a.m., 4:00 p.m. and 12:00 a.m., respectively. The rate will be adjusted the cost of maintaining a level of staffing that is at 86.5% of the base year level above the minimum requirement.

   This adjustment is calculated as follows:

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1. Determine the direct care hours per day from the base year cost report data for all private facility types.
2. Determine the direct care cost per day (including benefits) of the hours determined in 1 from the base year cost reports.

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3. Adjust the hours per day for the effect of the minimum wage requirement of HB 2019 by multiplying the factor determined in 2 by the percent of the cost of the minimum wage increase to the total salaries and benefits in the base period.
4. Determine the amount of hours per day in the base period that actual direct care hours exceeds the minimum requirement.
5. Apply a factor of .865 (86.5%) to the amount determined in 4. This is the estimated amount that the facilities will remain above the minimum required hours.
6. Add the amount determined in 5 to the amount of new required minimum hours per day to get the expected level of hours per day for the rate period. Divide the expected level of hours by the level of hours in the base year to get a percent increase.
7. The cost per day is determined by multiplying the percent in 6 by the cost in 3 to get the add-on. For the period beginning 09-01-00 this amount is $2.22.

The direct care staff-to-patient ratios required and the employees to be included in the ratios are defined in Section1-1925.2 of Title 63 of the Oklahoma Statutes. In general, direct care staff includes any nursing or therapy staff providing hands-on care. Prior to Sept. 1, 2002 Activity and Social Work staff not providing hands-on care are allowable. On Sept. 1, 2002 Activity and Social Work staff not providing hands-on care shall not be included in the direct care staff-to-patient ratios. The direct care staff-to-patient ratios will be monitored by the Authority through required monthly Quality of Care Reports. These reports and rules may be found in the Oklahoma Administrative Code at OAC 317:30-5-131.2. This section of the Code also includes rules for penalties for non-timely filing and the methods of collection of such penalties. Non compliance with the required staff-to-patient ratios will be forwarded to the Oklahoma State Department of Health who in turn under Title 63 Section 1-1912 through 1-1917 of the Oklahoma Statutes (and through the Oklahoma Administrative Act Code at 310:675) will determine "willful" non-compliance. The

Health Department will inform the Authority as to any penalties to collect by methods noted in OAC 317:30-5-131.2.

This add-on will be trended forward by the same method as in 3.A.4 on page 3.

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3. HB 2019 requires that all licensed nursing facilities pay a statewide average per patient day Quality of Care assessment fee based on 6% of the average gross revenue per patient day. An estimate of the Calendar 1999 surveys reporting this data was used to set the rate for the period beginning September 1, 2000.

   This estimate and rate adjustment will be $5.42 per day. For the period beginning October 1, 2000 the adjustment will be $5.63. The estimate was determined by adding the primary operating cost, administrative services component, capital allowance component and "other" components for the rate period and dividing that total by .94 to get the total rate including the 6% fee. The total fee is the difference between the totals above. The OHCA was also directed to collect the assessment, assess penalties for late payment and deposit the assessments into a "Quality of Care Fund" and make payments from said fund for the purposes listed in the Bill.

   The actual rate for the period beginning 09-01-00 will be determined from calendar 1999 surveys at a later date. When received, an adjusted rate will be established that reimburses the facilities for the estimated actual costs to be incurred during the rate period state fiscal year. Gross revenues are defined as Gross Receipts (i.e. total cash receipts less donations and contributions). For subsequent state fiscal years the per day assessment fee will be determined in advance from the totals of the monthly Quality of Care Reports, Section C, for the 6 month period from October 1 through March 31 of the prior fiscal year, annualizing those figures and determining the fee by dividing the total revenues by the total days and taking that result and multiplying by .06 (6%).

   For the rate period beginning 09-01-01 the rate component was adjusted to $6.05. This amount allows coverage of the provider

fee currently in effect which was set as of 07-01-01 as defined in D.3 above. The rate period adjustment was determined by multiplying the actual fee increase by 365 days and dividing by the days left in the rate period (304, i.e. 12 month's fees spread over ten months) and adding to the previous fee ($4.77).

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4. For the rate period beginning October 1, 2000 an adjustment of $3.33 per day will be added to the rate for the estimated cost of a minimum wage for specified salaries as mandated by HB 2019. The minimum wage will be $6.65 per day for the following specified positions: Registered nurse, Licensed practical nurse, Nurse aides, Certified medication aides, Dietary staff, Housekeeping staff, Maintenance staff, Laundry staff, Social service staff, and other activities staff. The OHCA will monitor this requirement and assess penalties as discussed in 2 above.

   The adjustment is determined as follows:

   1. Determine the total cost per day for salaries and wages for the Private ICF M/R facilities plus the Specialized ICF/MR 16 bed or less facilities.
   2. Determine the total cost per day for the Private NF's and the Private NF's Serving Aids patients.
   3. Determine the percent difference between 1 and 2. If the difference is positive leave the result as positive for the factor below in 7.
   4. Determine the total cost per hour for salaries and wages for the Private ICF M/R facilities plus the Specialized ICF/MR 16 bed or less facilities.
   5. Determine the total cost per hour for the Private NF's and the Private NF's Serving Aids patients.
   6. Determine the percent difference between 4 and 5. If the difference is positive then the result is negative for the factor below in 7.
   7. Determine the salary cost add-on differential for M/R facilities by adding the results in 4 and 6.
   8. Multiply this result by the add-on cost determined for Regular NF's on D.4, page 6.

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This add-on will be trended forward by the same method as in 3.A.4 on page 3.

5. For the rate period beginning December 1, 2000 the provider assessment fee set at September 1, 2000 will be adjusted to compensate for the actual fee determined by the surveys of data

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received. The rate adjustment needed for this decreased cost is $(1.20). Surveys were sent to the nursing facilities collecting revenue and patient day data for calendar 1999. Per HB2019 this data was to be used to set provider fee assessment rates for the different facility types. The assessment fee for the period beginning 09-01-00 was set at $4.77. This adjustment is needed for the remainder of the state fiscal year to appropriately reflect the actual costs and adjust for the estimated assessment reimbursement portion of the rate set at 09-01-00 and revised at 10-01-00 (see D.3 above). The adjustment needed was determined by multiplying the difference between the estimated assessment in the rates at 09-01 and the actual assessments from the surveys by the total months that a difference occurred and dividing this total by the estimated days remaining in the rate period. After the initial rate period these adjustments will be amended to an annual basis.

6. HB 2019 directed the Nursing Facilities and ICF's/MR to provide for dentures, eyeglasses and non-emergency transportation attendants for Medicaid clients in nursing facilities. For the rate period beginning December 1, 2000 the rate adjustment for the estimated cost of these added items of coverage is $2.45 per day.

   The costs were determined as follows:

   For the transportation travel attendant the base year cost report average hourly cost for a social worker was brought forward to the rate state fiscal year and an adjustment made for the effects of minimum wage and benefits. The cost of two FTE's per 100 bed home were determined by multiplying that total by 2080. From the cost report data percent of occupancy it was estimated that this 100 bed home would have 29,000 patient days which when

divided into the cost of the two FTE's gives an add-on of $1.78 per day.

For the cost of dentures it was estimated that 50% of the 25,000 Medicaid clients need eyeglasses once every three years. That correlates to an average of 4,165 services per year. The cost of those services was estimated at the Medicaid rates for one upper

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or lower one re-base and one reline (codes D5130, D5214, D5720 and D5751), or $567.47. This cost times the number of services divided by the estimated Medicaid patient days is the add-on needed for these services.

For the cost of eyeglasses the total number of services needed is 75% of the 25,000 total population of Medicaid patients. It is estimated that 80% of those need services, or 15,000. The average cost per service was determined to be the total for one lens plus one frame plus one exam (codes W0105 to 0109,V2020 and 92002/92012). This total average cost per service is multiplied by the estimated total services per year and divided by the total estimated Medicaid days to get the per diem add-on.

This add-on will be trended forward by the same method as in 3.A.4 on page 3.

7. For the rate period beginning December 1, 2000 the OHCA has added $2.69 to the rate to cover the loss of the "major fraction thereof" provision in meeting the minimum direct care staffing requirements. The add-on was determined as follows:

   1. The additional hours needed to cover the loss of the "major fraction thereof" provision in meeting the minimum staffing requirements was determined by arraying the required hours for levels of patients from 17 to 136 with the provision and without the provision. The average percent change in required hours was determined.
   2. The per day cost of the direct care salaries plus benefits was determined from the base year cost reports.

3. The cost in 2 above was increased by a factor to cover the minimum wage requirements of HB 2019. The factor was determined by dividing the cost per day added to the rate in D .4 above by the direct care cost per day in 2.
4. The factor in 3 was applied to the cost per day determined in 2 to get the current cost per day.
5. The cost per day determined in 4 was multiplied by the percent determined in 1 to determine the rate add-on required to fund the loss of the "major fraction thereof" provision.

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This add-on will be trended forward by the same method as in 3.A.4 on page 3.

D. Statewide Base Rate

The statewide facility base rate is the sum of the primary operating per diem, the administrative services per diem, the capital per diem and the adjustments for changes in law or regulation less the enhancement in 4 below.

4. **Enhancements**

The Authority may further adjust the statewide facility base rate to include estimates of the cost of enhancements in services that are not otherwise required by law but which the Authority wishes to recommend as the basis for inclusion in the ICF/MR rates.

Effective May 1, 1997 the State will pay an interim adjustment of $4.20 per diem for specified staff to facilities who have elected to participate in the wage enhancement program.

Allowable costs include the salaries and fringe benefits for the following classifications: licensed practical nurses (LPNs), nurse aides (NAs), certified medication aides (CMAs), social service director (SSDs), other social service staff (OSSS), activities directors (ADs), other activities staff (OAS), and therapy aid assistants (TAA). These classifications do not include contract staff.

A settlement will be made based on the variance in the amount of enhanced payments and the amount expended for wages and benefits paid for the specified staff. The settlement will be capped at $4.20 per day.

Facility-specific target rates were determined for each provider. Fiscal year 1995 costs were used to set the rates. The target rates were calculated as follows:

1. The reported salaries and wages for the specified staff were summed for each facility (specified staff salaries).
2. An employee benefits ratio was determined by dividing total facility benefits by total facility salaries and wages.

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3. Total specified staff salaries were multiplied by the employee benefits ratio calculated in 2 above, to determine allowable employee benefits.
4. Specified staff salaries and allowable employee benefits were summed and divided by total facility patient days to arrive at the base year allowable cost per diem.
5. The base year allowable cost per diem for each facility was trended forward by factors of 2.9 percent and 3.1 percent.
6. An adjustment of $4.20 per day was added to the trended base year costs to arrive at the target rate for each facility.
7. For facilities demonstrating compliance for two consecutive quarters as of June 30, 2000, the reporting requirement is waived. Facilities not in compliance or not participating at July 1, 2000 may not participate in the program and receive the enhanced rate adjustment of $4.20. New facilities and facilities under new ownership may participate in the wage enhancement program and will be subject to the compliance requirements of the program.

5. RATE ADJUSTMENTS BETWEEN REBASING PERIODS

A. Beginning January 1, 2001 the rates will be adjusted annually on January 1, in an amount equal to the estimated savings or loss to the program as a result of the automatic cost of living adjustment on Social Security benefits as published in the Federal Register and the resulting effect to the spenddown required of the recipients. The rate adjustment will be determined as follows: the most recent calendar year (CY) total spenddown for Medicaid clients determined from the MMIS (Medicaid Management Information System), will be adjusted

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to the rate period (CY) by the Social Security Cost of Living increases as published in the Federal Register. The resulting spenddown estimate will be divided by the most recent available SFY total Medicaid days from the MMIS to determine the rate adjustment.

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SPECIALIZED PRIVATE ICF/MR FACILITIES 16 BED OR LESS

A separate statewide prospective rate of payment shall be determined annually for specialized private intermediate care facilities for the mentally retarded with 16 beds or less (SF's/MR/16). These facilities must meet the higher direct care staffing requirements for licensure established by the Oklahoma State Department of Health for an SF/MR/16 serving severely impaired residents. SF'S/MR/16 must serve at least one severely or profoundly retarded resident or one who is moderately retarded and who is medically fragile or has serious physical or emotional problems. The rate will be determined pursuant to these methods and standards and approved by the Oklahoma Health Care Authority Board in advance of the rate period.

The rate will be established based on analyses of cost reports and other relevant cost information, the use of national and, where appropriate, Oklahoma-specific trends in costs, including trends in salary levels and changes in minimum wage levels, analyses of the economic impact of changes in law or regulations, and discussions with recognized representatives of the nursing home industry.

The rate is at, or above, the level that the Oklahoma Health Care Authority (OHCA) finds reasonable and adequate to reimburse the costs that must be incurred by economically and efficiently operated facilities to the extent specified by 42 U.S.C. Section 1396a(a)(13)(A).

A. COST ANALYSES

The Oklahoma Health Care Authority (OHCA) is principally responsible for implementing the Medicaid program in Oklahoma. OHCA staff will prepare necessary analyses to support the rate determination process, as described below.

1. UNIFORM COST REPORTS

Each Medicaid-participating SF/MR/16 facility must submit, on uniform cost reports designed by the Authority, cost and related statistical information necessary for rate determination.

a. **Reporting Period.** Each SF/MR/16 facility must prepare the cost report to reflect the allowable costs of services provided during the immediately preceding fiscal year ending June 30. Where the ownership or operation is commenced, a fractional year report is

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required, covering each period of time the SF/MR/16 was in operation during the year.

b. **Report Deadline.** The report must be filed by September 1 of each year. Extensions of not more than 30 days may be granted on a showing of just cause.

c. **Accounting Principles.** The report must be prepared on the basis of generally accepted accounting principles and the accrual basis of accounting, except as otherwise specified in the cost report instructions.

d. **Signature.** The cost report shall be signed by an owner, partner or corporate officer of the SF/MR/16, by an officer of the company that manages the NF, and by the person who prepared the report.

e. **Audits of Cost Reports.** The Authority will conduct a desk review to verify the completeness and mathematical accuracy of all totals and extensions in each cost report. Census information may be independently verified through other OHCA sources. In addition, a sample number of cost reports will be audited independently by an auditor retained by OHCA. Any SF/MR/16 that is subject to an audit is required to make its records available to OHCA and to any auditor engaged by OHCA.

2. **ALLOWABLE AND UNALLOWABLE COSTS**

Only "allowable costs" may be included in the cost reports. (Costs should be net of any offsets or credits.) Allowable costs include all items of Medicaid-covered expense that SF'S/MR/16 incur in the provision of routine (i.e., non-ancillary) services. "Routine services include, but are not limited to, regular room, dietary and nursing services, minor medical and surgical supplies, over-the-counter medications, transportation, and the use and maintenance of equipment and facilities essential to the provision of routine care. Allowable costs must be considered reasonable, necessary and proper, and shall include only those costs that are considered allowable for Medicare purposes and that are consistent with federal Medicaid requirements. (The guidelines for allowable costs in the Medicare program are set forth in the Medicare Provider Reimbursement Manual ("PRM"), HCFA-Pub. 15.) Ancillary items

reimbursed outside the SF/MR/16 rate should not be included in the ICF/MR cost report and are not allowable costs. Quality of Care assessment fees are allowable costs for reporting purposes.

3. **COMPUTATION OF THE STATEWIDE FACILITY BASE RATE**

Cost reports used to calculate the rate were those filed for the year ended June 30, 1999. ("base year"). A state plan will be submitted when costs are re-based. A description of the calculation of the base per diem rates for the periods beginning September 01, 2000, October 01, 2000, and December 01, 2000 are as follows:

A. Primary Operating Costs

1. Determine the weighted mean primary operating per diem by summing all reported primary operating expenses of all standard SF/MR/16 facilities and dividing by total period patient days. Primary operating costs consists of all non-capital costs excluding administrative services, which are described on page 4.

2. Determine the audit adjustment per diem to be extrapolated to all reporting facilities based on the desk reviews and independent sample audit findings. The audit adjustment is based on an average of the difference between the reported costs and audited costs. If no audit file is available, an average audit adjustment will be determined from the average audit adjustments for the last five available periods.

   For the rate period beginning 09-01-01 an audit adjustment which reflects the latest available audit data will be made. This adjustment will be made to the base primary operating cost before trending forward to the midpoint of the state fiscal year of the rate period by the factors defined in 3.A.4, below. The new adjustment will be the difference between the factor determined in the previous rate as defined above and the average of the three most current available years audit data on file.

3. Determine the adjusted primary operating per diem by subtracting the audit adjustment per diem (step 2) from the weighted mean primary operating costs per diem determined in step 1.

4. Trend forward the adjusted primary operating per diem from the midpoint of the base year to the midpoint of the rate period state fiscal year using the inflation update factors. The Authority will use the update factors published in the Data Resources, Inc., ("DRI") nursing home without capital market basket index for the fourth calendar quarter of the previous fiscal year.

   For example, for the rates effective July 1, 1997, the Authority used the update factors for the fourth quarter of calendar year 1996.

B. Administrative Services

An imputed administrative services allowance will be used in lieu of actual owner/administrator salary and non-salary compensation. The imputed administrative services allowance is the state-established limit or value for the purposes of calculating the reimbursement rate.

The base allowance will be the same as that determined for the regular Nursing facilities in 3.B on pages 3 and 4. The allowance will be trended forward in the same manner as in 3.B on page 4.

C. Capital

An imputed allowance will be used in lieu of actual depreciation, interest, and lease related to facilities and equipment. The imputed allowance is determined by dividing the total reported costs (from the base year cost reports) for the regular nursing facilities, plus that for the regular nursing facilities serving aids patients, plus that for the private standard intermediate care facilities for the mentally retarded plus that for the private specialized (16 bed or less) M/R facilities by the total "adjusted days" for those facilities. The "adjusted" days are determined by multiplying the allowable days from the base year cost report by a factor of .93 (i.e. adjust to a 93% occupancy level). To account for inflation this imputed capital allowance will be trended forward to the rate period state fiscal year by the Marshall-Swift replacement cost multipliers for facilities with Class C construction (District Comparative Cost Multipliers, Central Region) published in the January index of the year preceding the rate change period.

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D. Adjustment For Change In Law Or Regulation

The Authority also considers possible effects on rate year costs compared to base year costs that might not be fully accounted for by the DRI index described above. Inasmuch as the index is an estimate of actual and forecasted national rates of change in the price of nursing home goods and services, DRI is not specific to any state. Thus during a given period, it might not sufficiently account for the economic effects of changes in federal laws or regulations which have a disparate impact on Oklahoma, or of changes in state laws, rules or circumstances that only affect Oklahoma.

The following circumstances may cause an adjustment to rate year costs: additional costs incurred to meet new requirements imposed by government regulatory agencies, taxation, authorities, or applicable law (e.g., minimum staffing requirements, social security taxation of 501(c) (3) corporations, minimum wage change, etc.) and implementation of federal or state court orders and settlement agreements.

OHCA will evaluate available financial or statistical information, including data submitted on cost reports and special surveys to calculate any base rate adjustment. These adjustments will become permanent until such time a state plan amendment is submitted to rebase the rates.

Per HB 2019, the Oklahoma 2001 Health Care initiative, the following adjustments will be made.

1. For the rate period beginning September 1, 2000 the OHCA has calculated an Oklahoma Specific additional cost of expected increase in Liability insurance rates. The rate will be adjusted by an additional $.51 for the expected cost. The amount of additional cost was determined from a sample of nursing facility invoices from the 1999 and 2000 fiscal years and from data from the base year cost reports. The total sample costs for 1999 were compared to the total sample costs for 2000 to get an overall percent of increase. Total available days from the base year cost report was divided by 365 to estimate the number of beds which in turn was multiplied by an estimated annual cost of $100 per bed (per